INSTRUCTIONS FOR COMPLETING

ANNUAL UTILIZATION REPORT OF HOME HEALTH AGENCIES/HOSPICES

REPORT PERIOD
JANUARY 1, 2007 THROUGH DECEMBER 31, 2007

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
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Office of Statewide Health Planning and Development

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for
Report Periods Ended in 2007

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These are the instructions for completing the 2007 Annual Utilization Report of Home Health Agencies and Hospices. Sections 1 through 4 are to be completed by home health agencies; section 1 and sections 5 through 10 are to be completed by hospices. If the facility provides both Home Health and Hospice Services, all sections must be completed. Enter in sections 2 through 4 data pertaining to the home health agency, and in sections 5 through 10 enter information pertaining to the hospice. This document also contains a glossary of terms used in the Report.

Please call the Office of Statewide Health Planning and Development (OSHPD) Technical Support at (916) 326-3854 or hha-hospice-alirts@oshpd.ca.gov for questions or for further clarification.

GENERAL INSTRUCTIONS

1. Completion of this Annual Utilization Report of Home Health Agencies and Hospices is required by Section 74729, Division 5, Title 22, of the California Code of Regulations for Home Health Agencies, and Section 1750(c) of the California Health and Safety Code for Hospices. Failure to file a timely report may result in a suspended license by the Department of Health Services (DHS) until the report is completed and filed with OSHPD.

   There are 10 Sections in the Annual Utilization Report of Home Health Agencies and Hospices (AURHH). The AURHH is organized in a flexible manner to allow for varying utilization and operation characteristics among providers required to report. Facilities are categorized according to three entity types, **Home Health Agency Only; Home Health Agency and Hospice; and Hospice Only. Facilities should complete all sections or certain sections of the AURHH in keeping with the following general guidelines:**

   - Entity type Home Health Agency Only. Completes only Sections 1, 2, 3, and 4.
   - Entity type Home Health Agency and Hospice. Completes ALL sections.
   - Entity type Hospice Only. Completes only Sections 1, 5, 6, 7, 8, 9, and 10.
   - Entity type special circumstance. Home Health Agency that is a Licensed Pharmacy only providing home infusion equipment. Completes Section 1 and marks Section 2 question number 40 as a "No". (See further information within these AURHH Instructions.)

2. The standard report period for Annual Utilization Reports is from January 1 to December 31, unless there has been a change in licensure (ownership) during the calendar year. In such a case, the former licensee is responsible for submitting a report

that covers January 1 to the last date of licensure, while the new licensee is responsible for submitting a report that covers the effective date of licensure to December 31.

Note: Facilities are encouraged to request permission to submit a combined 12-month report if there has been a change in licensure during the calendar year. The former and current licensees need to agree which licensee will be responsible for submitting the report. Please send your request to file a combined report by e-mail to hha-hospice-alirts@oshpd.ca.gov, or contact OSHPD Technical Support for instructions.

If a facility opens or resumes operations during the year, the first utilization report would cover the period from the effective date of licensure to December 31. If a facility closes or suspends operations during the year, the final utilization report would cover from January 1 to the date of closure.

3. Since calendar year 2002, all facilities have been required to submit their Annual Utilization Reports using OSHPD's web-based Automated Licensing Information and Report Tracking System (ALIRTS). To use ALIRTS, facilities must have a PC with Internet access equipped with Internet Explorer (IE) Version 5.0 or higher with 128-bit encryption. Macintosh computers and Netscape browsers are not compatible with ALIRTS. Minimum PC requirements include a 133 MHz processor, at least 64 Mb of RAM, a 28.8 bps modem, and a printer. The PC and browser must be set to accept cookies and to open another window.

4. **Do not submit the hardcopy report to OSHPD**. Only facilities with prior formal written permission for modification of submission may use a different submission format.

5. Annual Utilization Reports are due on or before March 15 if the report is for a full 12-month report period. If the facility closes, the report is due 14 days from the date of notification from OSHPD.

6. Enter all amounts as whole numbers. Enter financial data to the nearest dollar. Do not use decimals, commas, dollar signs, spaces or special characters.

7. ALIRTS will calculate totals for a section or the entire report. Click on any "click to total" button within a section to calculate all of the totals in that section. Click on the "click to total" button at the end of the report to calculate all of the totals in the report.

8. When you have completed the report, scroll down to the end of the report and click on the "Validate & Save" button. If there are error messages in the "Errors and Warnings" box, you cannot submit the report. You need to correct and clear all the "Fatal" errors. For "Confirm" and "Explain" errors, you need to check the box under "Confirm" and type in your explanations. After you have completed this click on the "Validate & Save" button again. When all the "Fatal" errors are eliminated then you are ready to submit the report. Click on the "Submit" button and a screen will appear asking you to certify the accuracy of the report. If you agree with the terms, click on "OK". The report is now being submitted. A confirmation of the submitted report will appear. Click on the "Print" button for a hardcopy of the confirmation and keep this as your official record.

9. After the report has been submitted you can view the report in the ALIRTS system. Log into ALIRTS, go to the ALIRTS Home page and search for the OSHPD ID number or name of your facility, then select “view reports”. The report will be listed with a status of “SubmittedOriginal”. Select “View” to review the report. If you need to make any changes to the report, select “Revise”. You will open a copy of the originally submitted report. Make necessary changes and re-validate before submitting the report again. (While the report is being revised it will have the status of “In Process”). At this point, you will only be able to “View” the original report. When the “In Process” report is submitted the status will change to “SubmittedRevised”.

SECTION 1 – GENERAL INFORMATION AND CERTIFICATION

This section contains basic information about the facility and parent corporation, if any, and the person completing the report.

1. **Lines 1 - 5: Facility Name and Address**
   The facility information for lines 1 through 5 is automatically entered from OSHPD's Licensed Facility Information System (LFIS) based on data from the Department of Health Services (DHS) Licensing and Certification Division. If you find any discrepancies in this information, please notify us by e-mail at hha-hospice-alirts@oshpd.ca.gov or call (916) 326-3854.

2. **Lines 6 - 8: Facility Telephone Number, Administrator Name, and E-mail Address**
   Enter the facility's main telephone number on line 6 and the administrator's name on line 7. Enter the administrator's e-mail address on line 8 if one is available. The administrator's e-mail address will not be made available to the public.

3. **Line 9: Operation Status**
   On line 9, select "Yes" or "No" from the drop down menu to indicate whether or not the facility was in operation at any time during the year. If you selected "No" because the facility was not in operation during any day of the year, do not complete the rest of the report. Go to the end of the report and select the "submit" button to submit the report to OSHPD.

4. **Lines 10 - 11: Dates of Operation**
   If you answered "Yes" on line 9 because the facility was in operation during the year, enter the beginning and ending dates of operation on lines 10 and 11, respectively.

   Example – A facility began operation on April 15 and continued operation for the rest of the year. Line 10 would be 04/15/2007 and line 11 would be 12/31/2007.

5. **Lines 12 – 16: Parent Corporation Information**
   If the facility is a branch of another agency or a multiple location, enter the parent corporation's name, address and phone number on lines 12 through 16. If the facility is not a branch of another agency or a multiple location, leave these lines blank.

6. **Lines 17 – 20: Person Completing the Report (Report Contact Person)**
   The contact information on lines 17 through 20 will be filled in automatically based on the report preparer's registration information. The e-mail address on line 20 will not be made available to the public.

7. **Line 25: Entity Type**
   On line 25, select the appropriate entity type from the drop down box. Entity types are Home Health Agency Only, Home Health Agency and Hospice, and Hospice Only.

8. **Line 26: Entity Relation**
   On line 26, select the appropriate entity relation from the drop down box. Entity relations are parent, branch, and sole facility.

9. Lines 30 and 31: Submitted By and Submitted Date and Time

When the report is submitted, the ALIRTS application will supply the name of the person who submits the report and the date and time of the final report submission on lines 30 and 31, respectively. Before the report is submitted lines 30 and 31 will read, “Not submitted yet”.

SECTION 2 – FACILITY DESCRIPTION

This section includes information about the licensee type of control, certifications and accreditations, special services of the agency, and the number of patients seen by the agency. Hospice Only facilities do not complete section 2.

1. **Line 1: Licensee Type of Control**
   Select from the list from the drop down menu the category that best describes the agency's type of ownership.

2. **Line 5: Medicare/Medi-Cal Certification**
   Select from the drop down menu the type of certification the home health agency has from Medicare and Medi-Cal. Certification choices are Medicare only, Medicare and Medi-Cal, Medi-Cal only, or Neither.

3. **Lines 10 through 13: Agency Accreditation Status**
   On lines 10 through 13, select from the drop down box the status of the home health agency's accreditation with the listed organizations. Accreditation status can be Accredited, Deemed Status, and None.

   Line 10: ACHC – Accreditation Commission for Health Care
   Line 11: CHAP – Community Health Accreditation Program
   Line 12: JCAHO - Joint Commission on Accreditation of Healthcare Organizations
   Line 13: Other – Any other accrediting organization

4. **Lines 15 and 16: Home Infusion Therapy/Pharmacy Only**
   Line 15: Select "yes" or "no" from the drop down box to indicate whether or not the facility is a licensed Pharmacy.

   Line 16: Select "yes" or "no" from the drop down box to indicate whether or not the facility had a Registered Nurse on staff that made home visits.

   Note: If the facility is a licensed Pharmacy that only provides home infusion equipment, advance to Line 40 and select "No" from the drop down box. After doing so, submit the report to OSHPD. The rest of the report is not applicable.

5. **Lines 20 through 28: Special Services**
   On lines 20 through 28 check the box for each special service that applies to your facility.

6. **Line 30: Persons Receiving Services**
   Enter on line 30 the number of **unduplicated persons** seen by your agency during the reporting year. Be sure to count each person only once (See Glossary for definition.)

7. **Lines 31 through 33: Other Home Health Visits**
   Enter on lines 31 through 33 the total number of patient visits to your agency in each of the listed categories: Pre-Admission Screening/Evaluations, Outpatient Visits, and Other.

8. **Line 34: Total**
The ALIRTS application will complete the total Other Home Health Visits on line 34 with the sum of lines 31 through 33.

9. Lines 40 and 41: Other Home Health Services
These are services that are not traditional home health services. They may include Continuous Care Services (service must be provided for a minimum of 8 hours on a particular day), Private Duty or Shift Duty Nursing or Homemaker Services in a patient's home. The agency is reimbursed on a **SHIFT, DAY**, or **HOURLY BASIS**.

Line 40: Select "Yes" or "No" from the drop down box to indicate whether or not your agency have performed Other Home Care Services.

Note: If line 40 is "Yes", complete line 41 and lines 50 through 54 as applicable. If line 40 is "No", go to Section 3. **Reminder:** If your facility is a licensed Pharmacy that only provides home infusion equipment, select "No" for Line 40 and submit your report.

Line 41: Enter on line 41 the total number of hours of other Home Care your agency provided.

10. Lines 50 through 54: Other Home Care Services, Staff, and Functions
On lines 50 through 54 check the box for each Home Health Service or staff used by your agency to perform the Other Home Care Services.

SECTION 3 – HOME HEALTH AGENCY PATIENTS AND VISITS

This section provides information about the Home Health Agency's patients, visits, admissions and discharges. Hospice Only facilities do not complete section 3

1. **Lines 1 through 10: Patients And Visits By Age**

Column 1: Patients
Enter on lines 1 through 10 the total number of patients who received services from your agency in each of the listed age categories.

The term "patient" refers to that time period between the time a "person" is admitted for service and the time of discharge. Once the "person" is discharged from care then he/she is considered as one patient. If that "person" is re-admitted he/she is counted once again as a "patient" for purposes of Section 3. Note that this concept considers both the individual and the time under care, whereas "person" considers only the concept of the individual.

Example: Mrs. Green was in the care of a Home Health Agency at the beginning of 2007 and received visits during January. In February she was discharged. In November she was re-admitted for the same problem and received visits from agency staff during the remainder of the year and was still in the agency's care at the end of the year. Mrs. Green would be considered two "patients" for purposes of Section 3, but only one "person" for purposes of Section 2 (2.30.1).

In order to count an individual as a "patient" in a given year the Home Health Agency must have made a visit to the person's home during that year and provided the type of care for which the agency is authorized.

Persons enrolled with an agency near the end of the year but did not receive service prior to the end of the year are not to be counted as patients.

Example: Mrs. Jones was referred to a Home Health Agency on December 28, 2007 and was accepted as a patient. The first visit the nurse made to her home was January 6, 2008. Mrs. Jones would not be counted as a patient in 2007 because no services were rendered in 2007.

Persons who received care in the prior year, but were not formally discharged until the current year are not counted as patients in the current year.

Example: Mrs. Smith who was recovering from a broken hip, was last seen by the Home Health Agency's nurse on December 28, 2006. However, the discharge paperwork was not completed until January 10, 2007. Mrs. Smith would not be counted as a patient in 2007 because no services were rendered during that year.

Column 2: Visits
Enter on lines 1 through 10 the total number of visits to your agency in each of the listed age categories.

2. **Line 15: Total**
The ALIRTS application will complete the total patients and visits on line 15 with the sum of lines 1 through 10 for columns 1 and 2.

3. **Lines 21 through 34: Admission by Source of Referral**
Enter on lines 21 through 34 the number of new patients referred by each of the listed sources. See Glossary for definitions.

4. **Line 35: Total**
The ALIRTS application will complete the total admissions on line 35 with the sum of lines 21 through 34.

5. **Lines 41 through 59: Discharges By Reason**
Enter on lines 41 through 59 the total number of discharges associated with each of the listed reasons for discharge.

6. **Line 60: Total**
The ALIRTS application will complete the total discharges on line 60 with the sum of lines 41 through 59.

7. **Lines 71 through 84: Visits By Type Of Staff**
Enter on lines 71 through 84 the total number of visits by each type of staff.

8. **Line 85: Total**
The ALIRTS application will complete the total visits on line 85 with the sum of lines 71 through 84. The total visits on line 85 must agree with section 3, column 2, line 15.

9. **Lines 91 through 99: Visits By Primary Source of Payment**
Enter on lines 91 through 99 the total number of visits for each source of payment listed. See glossary for definitions of sources of payment.

10. **Line 100: Total**
The ALIRTS application will complete the total visits by source of payment on line 100 with the sum of lines 91 through 99. The total visits on line 100 must agree with section 3, column 2, line 15.

SECTION 4 – HEALTH CARE UTILIZATION

This section reports the number of the agency's patients and visits by principal diagnosis, and the number of patients and the number of visits by HIV and Alzheimer's disease patients. Hospice Only facilities do not complete section 4

1. **Lines 1 through 34: Patients and Visits By Principal Diagnosis For Which Care Was Given**

   Column 1: Patients
   Enter on lines 1 through 34 the total number of patients for each principal diagnosis. Patients are to be counted more than once if they are discharged and re-admitted with a different principal diagnosis during the reporting period. Be sure to report each patient only once for each principal diagnosis under which care was given.

   Column 2: Visits
   Enter on lines 1 through 34 the total number of visits by the agency to patients with each listed principal diagnosis.

2. **Line 45: Total Patients and Visits**
   The ALIRTS application will complete the total patients and visits on line 45 with the sum of lines 1 through 34 for columns 1 and 2.

3. **Line 51: HIV**

   Column 1: Patients
   Enter on line 51 the total patients who were diagnosed as having Human Immunodeficiency Virus (HIV) disease (ICD-9-CM code 042). This includes both principal and secondary diagnosis. As in past years, when completing the Annual Utilization Report of Home Health Agencies/Hospices, continue to report only aggregate de-identified data. For more information on ICD-9-CM codes, see "ICD-9-CM Professional for Physicians Volumes 1&2, International Classification of Diseases 9th Revision Clinical Modification, Sixth Edition, WWW.IngenixOnline.com

   Column 2: Visits
   Enter on line 51 the total visits to the agency by patients who were diagnosed as having Human Immunodeficiency Virus (HIV) disease (ICD-9-CM code 042).

4. **Line 52: Alzheimer's Disease**

   Column 1: Patients
   Enter on line 52 the total patients who were diagnosed as having Alzheimer's disease. This includes both principal and secondary diagnosis.

   Column 2: Visits
   Enter on line 52 the total visits by the agency to patients who were diagnosed as having Alzheimer's disease.

SECTION 5 – HOSPICE DESCRIPTION

This section reports information about the licensee type of control, certifications and accreditations for the hospice. It also reports the agency type for Medicare purposes and the setting in which service is delivered.

1. **Line 1: Licensee Type of Control**
   Select from the list from the drop down menu the category that best describes the hospice's type of ownership, i.e. the type of organization that owns the license of your hospice.

2. **Line 5: Medicare/Medi-Cal Certification**
   On line 5, select from the drop down menu the type of certification the hospice has from Medicare and Medi-Cal. Certifications are Medicare only, Medicare and Medi-Cal, Medi-Cal only, and neither.

3. **Lines 10 through 13: Hospice Accreditation Status**
   On lines 10 through 13, select from the drop down box the status of the hospice's accreditation status with each of the listed organizations. The accreditation status can be accredited, deemed status, and none. The organizations are:

   Line 10: ACHC – Accreditation Commission for Health Care
   Line 11: CHAP – Community Health Accreditation Program
   Line 12: JCAHO – Joint Commission on Accreditation of Healthcare Organizations
   Line 13: Other – Any other accrediting organization

4. **Line 20: Agency Type As Reported On Medicare Cost Report**
   On line 20, select from the drop down box the agency type as reported on the Medicare Cost Report. The agency types are: Free Standing, Hospital based, Home Health based, Long-Term Care Facility based, Veterans Administration based, and Other.

5. **Line 25: Location of Service Delivery**
   On line 25, select from the drop down menu the item that most closely describes the area in which the hospice provides service. The selections are: Primarily Urban, Primarily Rural, and Mixed Urban and Rural.

SECTION 6 – HOSPICE SERVICES

This section reports information about services provided by the hospice, such as bereavement services, volunteer services, additional and specialized services. It also reports visits by type of staff.

1. Lines 1 and 2: Bereavement Services

On lines 1 and 2 enter the number of people who received bereavement services from the hospice. Enter the number of survivors of hospice patients served on line 1, and the number of survivors of persons not receiving hospice care served on line 2.

2. Lines 3 through 5 and 7 through 9: Volunteer Services

Column 1: Number of Volunteers

Enter in column 1 the number of volunteers who served in each type of service.

Column 2: Volunteer Hours

Enter in column 2 the number of hours the volunteers spent in each type of service.

- Patient/Family – Volunteer hours provided to a particular patient/family member.
- Bereavement – Volunteer hours provided for bereavement care.
- Administrative – Volunteer hours provided for administrative work directly associated with patient care.
- Medicare Reportable Hours – Volunteer hours that Medicare allows hospices to count toward their 5% minimum hours per year, as defined by the Medicare Hospice Conditions of Participation. These would include all hours listed in the three previous categories and exclusive of the "Fundraising" and "Other" categories.

3. Lines 6 and 10: Total

The ALIRTS application will complete the total Medicare Reportable hours on line 6, column 2 with the sum of line 1 through 5. The application will complete the total number of volunteers on line 10, column 1, and the total volunteer hours on line 10, column 2 with the sum of lines 3 through 5 and 7 through 9.

4. Lines 11 through 16: Additional And Specialized Services

On lines 11 through 16, check each of the additional and specialized services that are either performed by or contracted by the hospice. Check each service that applies.

- Hospice Designated Inpatient Facility/Unit – A hospice inpatient facility or unit that is managed and staffed by the hospice program's employees.
- Specialized Pediatric Program – A program of specialized hospice care for pediatric patients from specifically trained pediatric hospice employees.
- Bereavement services to survivors of persons not receiving hospice care – Bereavement services that are offered to the community in general that has not received hospice care from the hospice program.
- Adult Day Care – A licensed adult day care program for hospice patients run by the hospice program.
- Specialized Palliative Care Program – A specialized program of care that provides palliative care to non-hospice benefit patients.
- Other – Any other specialized program.

5. Lines 21 through 29: Visits By Type Of Staff

On lines 21 through 29, enter the total visits by each type of staff listed. Be sure to include after-hours and bereavement visits.

6. Line 30: Total

The ALIRTS application will complete the total visits on line 30 with the sum of lines 21 through 29.

7. Line 40: Average Number of Visits Per Patient Days

The ALIRTS application will automatically calculate this. This is the result of total visits (Section 6, Line 30) divided by total patient days (Section 9, Line 10).

SECTION 7 – HOSPICE PATIENT INFORMATION

This section reports information about the patients of the hospice. It reports the number of patients by gender and by age, race, and ethnicity. It reports the number of admissions by source of referral and by county. It also reports discharges by reason, length of stay, and disposition.

1. **Lines 1 through 12: Unduplicated Hospice Patients By Gender And Age Category**
   On lines 1 through 12, enter the total number of male (column 1) and female (column 2), patients by each age category listed. Be sure to count each patient only once even though the patient may have received service more than once.

   Column 4: Total
   The ALIRTS application will complete the total unduplicated hospice patients in column 4 with the sum of columns 1 and 2.

2. **Line 15: Total**
   The ALIRTS application will complete the total patients on line 15 with the sum of lines 1 through 12 for columns 1, 2 and 4.

3. **Lines 21 through 25: Unduplicated Hospice Patients By Gender and Race**
   On lines 21 through 25, enter the total number of male (column 1) and female (column 2) patients by each race listed. Be sure to count each patient only once even though the patient may have received service more than once.

   Column 4: Total
   The ALIRTS application will complete the unduplicated hospice patients in column 4 with the sum of columns 1 and 2.

4. **Line 30: Total**
   The ALIRTS application will complete the total patients on line 30 with the sum of lines 21 through 25 for columns 1, 2 and 4.

5. **Lines 31 through 33: Unduplicated Hospice Patients By Gender And Ethnicity**
   On lines 31 through 33, enter the total number of male (column 1) and female (column 2) patients by each ethnicity listed. Be sure to count each patient only once even though the patient may have received service more than once.

   Column 4: Total
   The ALIRTS application will complete the unduplicated hospice patients in column 4 with the sum of columns 1 and 2.

6. **Line 35: Total**
   The ALIRTS application will complete the total patients on line 35 with the sum of lines 31 through 33 for columns 1, 2 and 4.

7. Lines 41 through 54: Hospice Patient Admissions By Source Of Referral

Enter on lines 41 through 54 the total number of patients admitted from each source of referral listed.

8. Line 55: Total

The ALIRTS application will complete the total admissions by source of referral on line 55 with the sum of lines 41 through 54.

9. Lines 61 through 69: Hospice Patients Discharged By Reason

Enter on lines 61 through 69 the total number of patients discharged for each of the reasons listed.

10. Line 70: Total

The ALIRTS application will complete the total patient discharges by reason on line 70 with the sum of lines 61 through 69.

11. Lines 71 through 84: Hospice Patients Discharged By Length Of Stay

Enter on lines 71 through 84 the total number of patients discharged after each length of stay listed.

12. Line 85: Total

The ALIRTS application will complete the total patient discharges by length of stay on line 85 with the sum of lines 71 through 84.

13. Lines 91 through 99: Hospice Patient Admissions By County and Discharges By Disposition

Column 1: County of Patient's Residence at Time of Admission

In column 1, select from the drop down box for lines 91 through 99, as necessary, each county from which patients were admitted.

Column 2: No. of Admissions

Enter in column 2 the total number of admissions for each county selected in column 1.

Column 3: No. of Deaths

Enter in column 3 the total number of deaths of patients from each county.

Column 4: No. of Non-Death Discharges

Enter in column 4 the total number of discharges that were for reasons other than the death of the patient.

Column 5: No. of Patients Served

Enter in column 5 the total number of patients served from each county. Be sure to count each patient only once even though they may have been served by the hospice more than once.

14. Line 100: Total

The ALIRTS application will complete the total on line 100 with the sum of lines 91 through 99 for columns 2 through 5.

SECTION 8 – HOSPICE UTILIZATION

This section provides the number of patient discharges, the visits for discharged patients, and the total days of care by principal diagnosis for the discharged patients.

1. **Lines 1 through 19: Discharged Hospice Patient's Visits and Patient Days By Diagnosis**
   Enter on lines 1 through 19 the total number of patient discharges (column 1), visits for discharged patients (column 2), and discharged patients total days of care (column 3) for each of the primary diagnosis listed.

   Note: Please provide the number of patients discharged during calendar year regardless of payment source. Count only those patients admitted under the principal diagnosis for hospice care. Report each patient only once. The ICD-9-CM codes are provided only as a guide for you. You may use your hospice's existing definitions for diagnosis groups or the LMRP diagnosis codes from your fiscal intermediary provided that they match in a general way with the ICD-9-CM codes suggested.

2. **Line 20: Total**
   The ALIRTS application will complete the totals on line 20 with the sum of lines 1 through 19.

SECTION 9 – HOSPICE CARE AND SOURCE OF PAYMENT

This section provides information about the types of hospice care and the source of payments for hospice care. Types of hospice care include routine home care, inpatient care, and respite care. This section also provides information about the location of the care provided.

1. Lines 1 through 9: Level of Care and Source of Payment

Column 1: No. of Patients Served
Enter in column 1 the total number of patients served in each of the payer categories listed on lines 1 through 9. See glossary for definitions of payer categories.

Columns 2 through 5: Days of Care
Enter in columns 2 through 5 the total number of days of routine home care (column 2), inpatient care (column 3), respite care (column 4), and continuous care (column 5) for each source of payment listed on lines 1 through 9. See glossary for definitions of types of care.

Note: Please provide patient days for all patients served, including those in nursing facilities during the calendar year reported. Patients who change primary pay source during the calendar year reported should be reported for each pay source with the number of days of care recorded for each source (count each day only once even if there is more than one pay source on any one day).

Column 6: Total Patient Care Days
The ALIRTS application will complete the total patient care days in column 6 with the sum of columns 2 through 5.

2. Line 10: Total

The ALIRTS application will complete the total on line 10 with the sum of lines 1 through 9 for columns 1 through 6.

3. Lines 21 through 29: Location of Care Provided

Columns 1 through 4: Days of Care
Enter in columns 1 through 4 the total number of days of routine home care (column 1), inpatient care (column 2), respite care (column 3), and continuous care (column 4) for each location of care listed on lines 21 through 29.

Column 5: Total Patient Care Days
The ALIRTS application will complete the total patient care days in column 5 with the sum of columns 1 through 4 for lines 21 through 29.

4. Line 30: Total

The ALIRTS application will complete the totals on line 30 with the sum of lines 21 through 29 for columns 1 through 5.

SECTION 10 – HOSPICE INCOME AND EXPENSES STATEMENT

This section includes information regarding the financial operations of the facility during the reporting period. Lines 30 through 59 provide an operating expense worksheet which lists facility expenses taken largely from the Medicare Cost Report. Lines 101 through 175 is a Hospice Income Statement showing Gross Patient Revenue, Write-Offs and Adjustments, Other Operating Revenue, Operating Expenses, and Income Tax resulting in the Net Income for the period.

If your Medicare Cost Report is not available, you may use data from the trial balance you prepared for submission to Medicare. If your fiscal year is not based on the calendar year, you may use data from the Cost Report for the fiscal period ending in this reporting period. In either case you need to submit a revised report when the final data are available.

Note: Enter amounts to the nearest dollar. Do not use decimal points or commas.

1. **Lines 30 through 57: Detail of Operating Expenses**
   Enter on lines 30 through 57 the total amount of operating expense for each of the categories listed. Appropriate line numbers are listed on corresponding lines in the column titled Medicare Cost Report Worksheet A, Column 10.

   Note: For lines 33 and 34 – Nursing Home- Room and Board SNF Medi-Cal Pass through Payments and Medi-Cal Room and Board Contractual Payments – See Glossary for explanation.

2. **Line 59: Total Operating Expenses**
   The ALIRTS application will complete the total operating expenses on line 59 with the sum of lines 30 through 57.

3. **Lines 101 through 109: Gross Patient Revenue**
   Enter on lines 101 through 109 the total gross patient revenue for each of the payer sources listed. See glossary for definitions of the payer sources.

4. **Line 110: Total Gross Patient Revenue**
   The ALIRTS application will complete the total gross patient revenue on line 110 with the sum of lines 101 through 109.

5. **Lines 111 through 119: Write-Offs and Adjustments**
   Enter on lines 111 through 119 the total of each type of write-off and adjustment listed. Do not enter write-offs and adjustments as negative amounts unless the account has a credit balance.

6. **Line 120: Total Write-Offs and Adjustments**
   The ALIRTS application will complete the total write-offs and adjustments on line 120 with the sum of lines 111 through 119.

7. **Line 125: Net Patient Revenue**
   The ALIRTS application will complete the net patient revenue on line 125 with the remainder of line 110 minus line 120.

8. Lines 131 through 139: Other Operating Revenue
Enter on lines 131 through 139 the total of each category of other operating revenue listed.

9. Line 140: Total Other Operating Revenue
The ALIRTS application will complete the total other operating revenue on line 140 with the sum of lines 131 through 139.

10. Line 145: Total Operating Revenue
The ALIRTS application will complete the total operating revenue on line 145 with the sum of lines 125 and 140.

11. Lines 151 through 159: Operating Expenses
The ALIRTS application will complete the operating expenses on lines 151 through 159 with the totals of the operating expense categories from the Detail of Operating Expenses, lines 30 through 57.

12. Line 160: Total Operating Expenses
The ALIRTS application will complete the total operating expenses on line 160 with the sum of lines 151 through 159.

13. Line 165: Net from Operations
The ALIRTS application will complete the net from operations on line 165 with the remainder of line 145 minus line 160.

14. Line 170: Income Tax
Enter on line 170 the total amount of your income tax liability.

15. Line 175: Net Income
The ALIRTS application will complete the net income on line 175 with the remainder of line 165 minus line 170.

GLOSSARY
ANNUAL UTILIZATION REPORT OF HOME HEALTH AGENCIES/HOSPICES

ACHC

ACHC is the acronym for Accreditation Commission for Health Care.

Adult Day Care

Adult Day Care Facilities (ADCF) are facilities of any capacity that provide programs for frail elderly and developmentally disabled and/or mentally disabled adults in a day care setting.

ARF

ARF is the acronym for Adult Residential Facility. An ARF is licensed by the Department of Social Services, Community Care Licensing Division.

Bereavement Services to Survivors of Persons not Receiving Hospice Care

These are bereavement services that are provided to individuals who have suffered a loss, and the hospice program had not served the person who died.

CHAP

Acronym for Community Health Accreditation Program

CLHF

CLHF is the acronym for Congregate Living Health Facility as licensed by the Department of Health Services, Licensing and Certification Division.

Continuous Home Care Day

A continuous home care day is a day that consists of a minimum of 8 hours and a maximum of 24 hours of predominantly nursing care (RN and LVN) to manage the care of a patient during a period of crisis at the patient's place of residence.

Dedicated Facility or Unit

A dedicated hospice facility or unit consists of multiple beds grouped as a unit either as a facility or in a facility, owned or operated by the hospice, staffed by hospice staff, with major policies/procedures set by the hospice. A dedicated hospice unit or facility may be licensed as a residential care facility, a congregated living health facility, a skilled nursing facility, or a hospital.

Deemed Status

Instead of state surveys, the accrediting organization has regulatory authorization to survey agencies providing hospice services, to determine whether they meet the Medicare Conditions of Participation (COPs).

Encounters

Count one encounter each time a patient is seen by a health care service provider who exercises independent judgment in the provision of health services to the patient and records the encounter in the patient's record.

Enterostomal Therapy

This is a specialty area of nursing that provides preventive, acute and rehabilitative care for patients with select disorders of the gastrointestinal, genitourinary, and integumentary (skin) systems.

Ethnicity – Hispanic

A person with Hispanic ethnicity is one who identifies with or is of Mexican, Puerto Rican, Cuban, Central or South America, or other Spanish culture or origin regardless of race.

Facility Name

This is the name under which the facility is doing business (DBA name). This name may be an abbreviation of and may differ from the facility's legal name. It is listed on the license as the name of the facility being operated by the licensee.

General Inpatient Care Day

A general inpatient care day is a day on which the hospice patient receives care in an inpatient facility for pain control or acute or chronic symptom management that cannot be managed in other settings.

HMO/PPO

HMO/PPO is the acronym for Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO). HMO/PPO patients are patients enrolled in a managed care health plan to receive health care from providers on a pre-negotiated or per diem basis, usually involving utilization review. This includes HMO, PPO, Health Maintenance Organizations with Point-of-Service option (POS), Exclusive Provider Organizations (EPO), Exclusive Provider Organizations with Point-of-Service option, etc.

Hospice, Free Standing

This is a hospice that is not part of any other type of participating provider and is defined as a free standing hospice by your Fiscal Intermediary.

Hospice, Home Health Agency-based

The hospice is owned by or affiliated with a home health agency and the fiscal intermediary considers the hospice to be home health agency-based.

Hospice, Hospital-based

The hospice is owned or affiliated with a hospital and the fiscal intermediary considers the hospice to be hospital-based.

Hospice, Nursing Home-Based

The hospice is owned or affiliated with a nursing home facility and the fiscal intermediary considers the hospice to be nursing home-based.

Hospice, Special Hospital

A hospice inpatient facility licensed as a Special Hospital Hospice by the Department of Health Services.

Inpatient Respite Care Day

An inpatient respite care day is a day on which the hospice patient receives care in an inpatient facility when it is necessary to relieve the family members or other persons caring for the patient.

JCAHO

JCAHO is the acronym for Joint Commission on Accreditation of Healthcare Organizations.

Levels of Care

The four levels of care as defined by Medicare including Routine Home Care, Inpatient Respite, Continuous Care and General Inpatient.

License Category

The license category describes the licenses issued to specialty clinics by DHS, Licensing and Certification Division. License categories include Alternate Birthing Center, Psychology, Surgical, Dialysis, and Rehabilitation.

Licensee Type of Control

This describes the type of organization, either public (governmental) or private, that owns the license. The categories are listed below:

- City and/or County
- District
- Non-Profit Corporation (incl. Church-Related)
- University of California
- State
- Investor – Individual
- Investor – Partnership
- Investor – Limited Liability Company
- Investor – Corporation

Medi-Cal

The Medi-Cal payer source includes patients who are qualified as needy under state laws and are enrolled in Medi-Cal. Medi-Cal HMO should be reported under HMO/PPO.

Medicare

The Medicare payer source includes patients covered under the Social Security Amendments of 1965. These patients are primarily the aged and needy. Medicare HMO should be reported under HMO/PPO.

MSSP

Acronym for Multipurpose Senior Service Program, a program of the California Department of Aging that provides social and health care management for frail elderly clients who are certifiable for placement in a nursing facility but who wish to remain in the community. The goal of the program is to arrange for and monitor the use of community services to prevent or delay premature institutional placement of these frail clients.

OSHPD ID Number

This is a nine-digit facility identification number assigned by OSHPD for reporting purposes. The first three digits indicate the type of facility, the next two digits indicate the county in which the facility operates, and the last four digits are assigned to identify the facility.

Other Clinical Services

This includes physical, occupational and speech therapy, services from dietitians, musical and pet therapy, or any other clinical services.

Parent Corporation

A parent corporation is an agency of which the facility is a branch or a multiple location. Either the facility or the parent corporation may hold the license.

Patient

A patient is an individual who is receiving services from an agency between the time of admission and the time of discharge. This individual is considered to be one patient between the time of admission and the time of discharge. If this person is discharged then re-admitted to the agency he/she will be counted as a second patient (even though it is only one person).

Person

A person is an individual who has been admitted to an agency and receives services during the course of the year in question. This refers to the human being as opposed to the concept of "patient", which takes into account the admission and discharge status of the person. The count of persons is an unduplicated count of individuals, while a count of patients considers whether the person was discharged then re-admitted to service.

RCFE

RCFE is the acronym for Residential Care Facility for the Elderly as licensed by the Department of Social Services, Community Care Licensing Division.

Race – Asian/Pacific Islander

A person having origins in or who identifies with any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This includes Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, Vietnam, Hawaii, Guam, Samoa and other Pacific Islands.

Race – Black

A person having origins in or who identifies with any of the black racial groups of Africa.

Race – Native American

A person having origins in or who identifies with any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.

Race – Other/Unknown

Any possible options not covered in the other race categories.

Race – White

A person having origins in or who identifies with any of the original peoples of Europe, the Middle East, or North Africa. This includes Ireland, Germany, Italy, Near East, Arabia or Poland.

Respite Care

Respite care refers to short term, temporary care provided to people with disabilities in order that their families can take a break from the daily routine of caregiving. Unlike childcare, respite services may sometimes involve overnight care for an extended period of time.

Room & Board SNF Medi-Cal Pass through and Contractual Payments

When a hospice patient resides in a skilled nursing facility, and is eligible for the room and board payment covered under Medi-Cal, the hospice must bill for these services on behalf of the SNF. The hospice is paid only 95% of what the SNF would have been paid directly by Medi-Cal. The hospice must pay the SNF the room and board payment. Although the hospice may contract to pay the SNF any rate, it frequently is at 100% of what the SNF would have been paid if the hospice was not involved with the patient. The 5% net loss is considered one of the operating expenses.

Routine Home Care Day

A routine home care day is a day on which the hospice patient is at home and not receiving continuous home care.

Specialized Palliative Care Program

A program of care for those not eligible for or who have not elected hospice care that provides interdisciplinary care for patients and their families aimed at preventing and relieving suffering and promoting quality of life.

Specialized Pediatric Program

An identifiable specialized hospice program that seeks ongoing admissions of pediatric patients who are cared for by specifically trained pediatric hospice staff knowledgeable in pediatric pain and symptom management as well as the emotional and spiritual needs of pediatric patients and their families.

Surgical Operations

A surgical operation occurs when one patient uses an operating room. Therefore, a surgery involving multiple procedures (even multiple, unrelated surgeries) performed during one scheduling is to be counted as one surgical operation. Another definition of a surgical operation could be a "patient scheduling".

TRICARE (CHAMPUS)

TRICARE is a regionally managed health care program for active duty and retired members of the uniformed services, their families, and survivors. TRICARE brings together the health care resources of the Army, Navy and Air Force and supplements them with networks of civilian health care professionals to provide better access and high quality service while maintaining the capability to support military operations. TRICARE was formerly known as CHAMPUS.

Unduplicated Patients

This is for all patients who received care as of the first day of the reporting calendar year including those patients who received service in the previous calendar year and all patients admitted during the year. If a patient is admitted and discharged (services terminated) and then was re-admitted under a new agreement or contract then he/she should be counted twice for that year.